How Do We Implement the Recommendations of Karnataka's Task Force on Health and Family Welfare?

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CBPS Monographs

- "Decentralisation From Above - Panchayat Raj in the 1990s," by Vinod Vyasulu, March 2000.
- "Democracy and Decentralisation: A Study of Local Budgets in two Districts of Karnataka," A. Indira, et al., March 2000.
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How Do We Implement the Recommendations of Karnataka's Task Force on Health and Family Welfare?

An intervention in the debate opened up by the Final report of the Government of Karnataka's *The Taskforce on Health and Family Welfare*

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Acknowledgements

The document began as a review of the Report produced by the Taskforce on Health and Family Welfare, a Taskforce comprised of dedicated health scholars working in Karnataka. The nature of the document changed once we had studied the Taskforce's report and attended discussions on the same. It now stands as an added voice to the discussion on how to implement the Taskforce's massive recommendations to improve health and the healthcare system in Karnataka. Our intent in writing this document is to add an alternate point of view, hopefully one that is constructive to an ongoing debate on improving health in Karnataka. It is in accord with the Taskforce's sentiment of making this planning process a participative, reiterative one that results in implementation, carried out much less in haste but more with careful deliberation and thought.

Development of this document has been an evolutionary process, with constructive feedback from many a knowledgeable and learned resource. Dr. K.S. Krishnaswamy was considerate in sharing his insights and considerable expertise on the subject; he also took the time to moderate an Advisory Council workshop held at the CBPS offices on September 30, 2001. The dialogue and feedback from the workshop was invaluable, suggestions of which I hope are wisely incorporated in the document. The CBPS Advisory Council and colleagues who graciously took time on a Sunday afternoon to participate in the workshop and provide thoughtful comments included A. Indira, Vinod Vyasulu, Meenakshi Rajeev, Poornima Vyasulu, Ramesh Kanbargi, Gopukumar, Shyama Narang, Jayasimha K., Sandhya Rao, S. Rajagopalan and S. Sadhanand.

I am grateful to Dr. Vinod Vyasulu for first proposing this endeavor, and then for providing support, encouragement, and at times prompting, for carrying it forward. Likewise, I am appreciative of my colleagues, Jayasimha, Indira and Meenakshi's, support through what seemed an arduous path. Dr. Kanbargi was kind enough to read the final draft and offer his comments as was Dr. Vijayalakshmi. I am also thankful to Taskforce members who took time to share their thoughts about the Report. Dr. Sudarshan was generous to discuss the subject on the occasions when I met him and graciously agreed to write the Foreword. Dr. Thelma Narayan and Dr. C.M. Francis cheered the Center's efforts to be involved in areas of health and encouraged the work that was undertaken. In fact they proposed CBPS carry out additional work related to healthcare budgets.

These reiterative and, what at times might have seemed repetitive discussions to them, helped me coalesce my thoughts into a more cohesive document. It is my hope that the document adds value to the ongoing discussion on health in Karnataka.

Foreword

The Task Force is happy that the Centre for Budget and Policy Studies (M.A. Deepa, Health Consultant) has studied the Report of the Task Force and has made a number of serious observations. The Task Force is thankful to the Centre for this valuable contribution to the on-going discussion.

The document has gone through the various observations, findings and recommendations made by the Task Force. It is generally complementary. The emphasis varies and is to be expected knowing the different perspectives. The emphasis of the Task Force has been on Primary Health Care and Public Health. The Task Force has worked towards bringing about Equity, Quality and Integrity.

We are thankful that the document emphasizes the role of Panchayat Raj in health care. The Task Force has brought out the place of local government (Zilla, taluk and gram panchayats) and the need for decentralization. It is in view of the need for decentralisation that the Task Force has recommended the creation of a District Cadre and State Cadre. It is the local people who know best their local problems and needs. These must be addressed. The Task Force has therefore addressed this issue, starting with the formation of the Village Health Committee (as part of the Village Development Committee). The Task Force is aware of difficulties in recruiting and retaining staff, including doctors, nurses, laboratory technicians and pharmacists to serve in the peripheral health care institutions.

We recognize the role of elected members at the various levels-the District, Taluk and Gram Sabha. Their active involvement can improve the health care services at the local level. At the same time, we realize that health care involves certain capabilities: knowledge, skills and attitude. It is necessary to enable and empower the elected representatives to discharge their responsibilities efficiently and effectively by training. Mistakes can be costly and must be avoided. That is why it has been suggested that the administrative powers must be with the Panchayat Raj Institutions but technical supervision must be provided by the Health Department (who have the expertise and experience). The Department of Health will serve the Panchayat Raj Institutions to achieve their objectives in health.

The document has quoted the experience of Madhya Pradesh. The Task Force has had the benefit of the relevant documents of Madhya Pradesh and of discussions with the persons involved in their formulation and implementation. The Madhya Pradesh Education Guarantee Scheme has been successful. The Swasth Jeevan Seva Guarantee Scheme is good in its concept. The Task Force would like a modified scheme of Health Guarantee to be brought about in Karnataka. We have to avoid the pitfalls. Some of us have been involved in the "Jeevan Swasth Rakshak" scheme of Madhya Pradesh, which generated its own problems and for which solutions have to be found.

The idea of People's Health Survey is very good and the Task Force has recommended it as also decentralized planning. We would like planning to be initiated at the village level and the plans to be integrated at the Taluk and district levels. The State level planning will then be formulated based on them.

The document asks for "discussions between the Health Department and other departments at the State impacting health". That is the way the Task Force had been working even before the final report. The process is continuing. The Government has constituted, on the recommendations of the Task Force, Implementation Committees. On intersectoral issues, the Committee is chaired by the Additional Chief Secretary and has Secretaries from Finance and other sectors as members. The other committee is chaired by the Principal Secretary, Health, and has the Commissioner for Health and Officers of the Directorates as members. The Chairman, Task Force, is a member of both committees and he discusses all matters with members of the Task Force.

"Notion of promotion ..... is counter-productive to the objectives of building local commitment". While local commitment is essential, it is necessary to ensure the availability and experience of senior members of the Staff at state level. It is also necessary that the personal objectives must be catered to. The staff must have something higher to achieve.

The document makes a strong recommendation for data Collection, analysis, dissemination. The Task Force is already involved in developing a comprehensive Health Management Information System. This includes Disease Surveillance, Health Administration / Organisation and Geographical Information System. Such a comprehensive system can ensure better and quicker responses to the health needs of the people. Disease surveillance will involve all the people including the people of the area and the private practitioners of the different systems of Medicine.

In the section V. Conclusion, the document states: "Task Force's expertise is necessary in assisting the Department define goals and set priorities". The Task Force has been helping and continues to help the department in these and other functions. The Task Force wants the Department to discharge its responsibilities and has offered all help to ensure continuous improvement.

The Task Force believes that **the people have to attain and maintain health**. The Department of Health and allied departments can help the people by an enabling process. Our motto is "Health for all - now". People have waited for long. We must discharge our duties and responsibilities to enable them to be healthy without any further delay and with **equity** (the 'all' in health for all) and **quality**.

Bangalore
27 December 2001

Dr. H. Sudarshan
Chairman, Task Force on Health and Family Welfare
Government of Karnataka

How Do We Implement the Recommendations of Karnataka's Task Force on Health and Family Welfare?

I. Introduction & Background

The realm of health is important to every person. Public health contends it is government that is responsible for the health of its citizens. Therefore, the responsibility of the government would be to create an environment in which people are healthy. This entails addressing the determinants of health, such as water supply, sanitation, education and nutrition, in addition to the actual delivery of healthcare services, running of health centers and hospitals, along with a host of related subjects, such as quality standards for care, medical education system and healthcare finance.

In comparison to other states' health indicators, Karnataka is considered average. The last few decades has seen the State take several steps to address the issue of health, including adoption of the National Health Policy and other State initiatives to meet Health for All goals. There have been significant improvements in health status in Karnataka over the last three decades. Infant mortality has dropped as has the birth rate and the death rate. During the same time, life expectancy has increased significantly. In addition, the state can boast of a network of healthcare institutions that provide comprehensive healthcare services and have been built with consideration for population norms. More recently, 240 institutions, training students in healthcare, have been brought under the umbrella of the Rajiv Gandhi University of Health Sciences. All this is true. It is also true that wide gaps exist in the need for healthcare services. So do disparities based on geography, gender and socioeconomic status, and inadequate systems, especially public health systems, to address the determinants of health.

Karnataka Chief Minister, S.M. Krishna constituted a Taskforce on Health & Family Welfare in 1999 to write a report on the status of health in Karnataka and the healthcare delivery system. Specifically he charged the Taskforce to address a) public health concerns; b) management of the Department of Health and Family Welfare; c) medical and public health education systems, and d) proposals for stabilization of the population. Headed by Dr. H. Sudarshan, an eminent scholar in healthcare and supported by a team of health experts as members, the Taskforce is a competent, credible body that undertook the Chief Minister's challenge. The Taskforce itself was given broad capacity in which to conduct deliberations and address issues it felt were important. In a remarkably short duration the Taskforce assessed the status and issued its findings

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along with a set of recommendations that emphasizes public health in a volume titled "Towards Equity, Quality and Integrity in Health: Final Report of the Taskforce on Health & Family Welfare," hereinafter referred to as Report.

The subjects reviewed in the Report are extensive covering everything from healthcare research, to quality of care standards, to raising awareness for public health in the population, to women and children's health, to biohazardous waste disposal, to Panchayat governance systems, and to Indian Systems of Medicine & Homeopathy. It is quite comprehensive in that respect. And in each instance, the Taskforce has reviewed the subject in depth and issued recommendations to address specific shortcomings in that area.

The Report itself is a voluminous five hundred plus pages and adds up to a handbook on all subjects related to healthcare and healthcare delivery. For instance it notes that healthcare research in Karnataka is woeful. Therefore it proceeds to outline recommendations that begin with crafting vision, mission and values for healthcare research and continues by describing scope of research subjects. But the question of what to implement first, medical research or establishing quality standards of care is not answered.

As the government prepares to implement the Taskforce's recommendations, the Center for Budget and Policy Studies decided to examine the lengthy list of recommendations in the Report with an eye to its implementation. (The Center had earlier undertaken a study of health budgets for the Taskforce, and has been an active participant in the discussions) Taskforce members concede that implementation of recommendations is no easy task given the constraints of time, financial, political and personnel resources. Interestingly, the Department has accepted and implemented several interim recommendation made by the Taskforce indicating an imperative political will and a receptive management environment for improvements. Under these circumstances, the Center for Budget and Policy Studies endeavors to highlight issues it feels are important to implementation. CBPS does not attempt to prioritize health issues, for instance children's health vs. reproductive health vs. nutrition. Ample expertise is available on the Taskforce for this purpose. Instead, CBPS adds its voice to a discussion on the proposed healthcare infrastructure, a critical component of a robust healthcare system.

Our document has been organized in a way to give the reader an introduction to the Taskforce's work and then to add our voice to the discussion. The first section describes Taskforce's findings related to health infrastructure. It is in essence a summary of the Taskforce's Report. Where possible, the Taskforce's analysis or logic is presented to describe the findings. The next section describes the Taskforce's recommendations. It is in no way all encompassing of the work of

the Taskforce but pertains primarily to the Taskforce's mandate. And the last section discusses CBPS team's thoughts about how to administratively tackle the Taskforce's mandate. (Please note that this document does not address population stabilization, eventhough it is one of the mandates. The team feels the issue should be addressed in the context of strengthening the health infrastructure and after other more pressing priorities have been addressed.)

II. Taskforce Report Findings

The Taskforce undertook a fastidious review of the status of healthcare in Karnataka using existing data, or commissioning studies when data was not available. Scope of review was broad and included determinants impacting health, intersectoral cooperation (which really refers to collaboration between departments at the State level), functioning of the department itself and specific disease programs. The Taskforce proceeded to provide recommendations, broad and narrow in stroke for each subject reviewed.

A. Public Health

Public Health addresses issues of health for populations as opposed to the health of an individual. One of the goals of Public Health, a definition used by the Taskforce to serve as a practical guide, is to "reduce the amount of disease, premature death and disease-produced discomfort and disability in the population." Needless to say, areas that could potentially come under the field of Public Health are broad. It is inevitable that the scope is broad because the determinants for health and disease are multifarious. As the Department is responsible for healthcare, it ought to be on the forefront of health care issues, particularly public health. Indeed it is one of the Taskforce's mandate to address issues of public health. However, a major finding of the Taskforce was the absence of public health emphasis in the Department, whether in orientation of healthcare programs, staff training or any other aspect of department function.

Determinants

Determinants refer to factors that are known to influence health of a population. These include nutrition, water supply and sanitation, housing, literacy and poverty. The fact that each of the determinants mentioned is an issue handled by separate departments at the State level is an indication of the hurdles the health department faces in addressing public health concerns. The Report identifies several opportunities to maximize effectiveness of healthcare programs through schools. For instance, schools provide a model setting to disseminate health promotion programs.

But in order to do so, it must work in concert with the Department of Education. But the Department of Education works independently from the Department of Health. There is a lack of cooperation between Departments and a lack of awareness that it may be working towards same goals. A mutually beneficial program such as establishment of school health dispensaries, something that would benefit the Department of Education by increasing attendance and performance and the Department of Health by targeting healthcare service delivery, is not a viable option even for discussion under present circumstances. Without awareness it is not possible to consider comprehensive policy or carry out long term planning.

To give an example of the hurdles, one could consider the case of Water and Sanitation. In Karnataka only 86% of the population has access to safe water supply and only 53% have access to sanitation. Inadequacies of sanitation combined with shortages of safe water are the cause of several water borne diseases. Approximately 10% of total disease burden is related to inadequate water supply or to poor quality of water itself. The healthcare system typically treats the symptoms of these diseases but does not address the root cause or pathways involved in causing disease. Managing the issue is necessarily a multidisciplinary and intersectoral one. However, Water and Sanitation is handled by a separate department. And, there is little dialogue with the Department of Health to coordinate their efforts leaving people's health, along with state resources to suffer the consequences.

Primary Healthcare

There can be a great deal of synergy in using primary healthcare to achieve desired health status of a population but that link too has not been fully utilized. Instead, primary healthcare continues to be used primarily to treat acute conditions. The neglect of primary health care can be seen by the following additional findings. Primary health centers do not function or are not equipped at optimal levels. Updates to technology at primary care centers are very slow. Avenues for preventive and promotive health, such as nutrition, immunizations, antenatal care have faced declining expenditures over the last few years. In addition to a lack of emphasis, primary healthcare delivered by the department is not integrated with various externally aided projects such as RCH, TB, or Blindness. The result is that a person treated under the RCH program receives care pertaining only to services covered under that program. Routine conditions or care outside the purview of RCH are not addressed, leading to a patchy delivery of services. Spending on healthcare, both private and public, accounted for 6% of Gross Domestic Product (GDP). Surprisingly, 78% of total health spending is in the private sector, which as the Taskforce notes is mostly out of pocket expenses borne by an individual/families. And of this percent, an alarmingly high percentage, 82% goes towards primary healthcare. Medical expenditure

accounts for the "second highest cause of rural indebtedness." (p 393, Report) Data is a gross indicator of healthcare needs, possibly a failure of the Departments' healthcare delivery system to meet primary health needs of the population.

The Department does have an expectation that general practitioners, local healers, NGOs, private sector practitioners will supplement state's primary healthcare. However, community participation is not maximized to tailor a government program that meets primary healthcare needs. The Report finds that if there is involvement it is passive and ad hoc.

Disease Surveillance

One of the other findings is that there does not exist a coordinated, comprehensive data collection and analysis system today for disease surveillance. Existing disease surveillance measures are neither well known nor practiced. While data is available, it is available under the auspices of specific programs or within departments not connected to health. The current system is based on data collected at the health centers by Department clinical staff. No system exists to incorporate data from private healthcare sites into a disease surveillance system. There is no single source that can paint an illustrative & comprehensive picture of health.

Because data is collected from various sources, there is no standardization of the data being analyzed. There are variances in what ought to be standard health measures such as IMR and LBW. In addition, data collection methodology varies to such an extent that when one is sharing data, the source seems to indicate varying levels of data integrity.

Unfortunately, when data is collected at the Department's delivery sites, it is used for statistical purposes at the state level and not as an active tool for disease intervention at the local level. An effective system of Disease Surveillance must collect information from the general populace to identify, detect, monitor and apply interventions well in advance of an epidemic.

B. Healthcare Infrastructure

Any work that attempts to improve the health in Karnataka, which is arguably the responsibility of the Department, should at some point look at the functioning of the Department itself. The Department of Health & Family Welfare is seen as the infrastructure core around which the planning and delivery system is based. Management of the Department is the second subject tasked of the Taskforce. And the issues facing the department in meetings its obligations are many. First among them is the subject of public health.

Healthcare infrastructure should be organized in such a way as to support policies of the Department. Healthcare infrastructure refers to Department leadership, staff functioning at healthcare centers and all other aspects of administration. Significant findings in this area include a weak political will for health and leaders missing broad vision for health. More significantly, leadership is not problem solving oriented. Budgets tend to be stagnant or underutilized and the Department is found to engage in non-evidence based planning, administration, supervision and evaluation of the healthcare system.

Corruption is noted as a major problem pervading the bureaucracy, not just the Health Department. However the fact that it does exist within the health department and its healthcare delivery sites in insidious ways is reason enough for corruption to be addressed by the Department. For instance, Department hospitals have been found to charge patients a monetary sum for services or equipment that are to be provided free of cost. Physicians practicing at a PHC are regularly absent during office hours. Furthermore, several physicians embark on private practice in contradiction to the terms of their service with the Department. There is yet another more subtle form of corruption, staff transfers wherein preferential treatment is conferred to selected candidates.

Department Management

The Report notes a lack of emphasis on public health in the department. In fact, the Public Health basis around which the department was initially built has completely deteriorated. Public Health essentials are missing, such as nonfunctioning Disease Surveillance System, absence of a Division addressing public health and lack of coordination with other Departments that impact health.

Second and in a related subject, the Report recognizes lack of transparency as another significant impediment to effecting Department functioning. Lack of administrative transparency could foster corruption of various sorts. Several procedures in the Department are not open to public or Department review. Ambiguity in decision making for transfers is a good example of how it can be misused for the benefit of some and detriment of others. Similarly, the budget process needs closer examination. Though the budget planning process runs like a well-oiled machine, even health expenditure data is difficult to access. Rationale for assigning budget priorities is unclear. The only available information regarding priorities has to be inferred from the previous year's fiscal data.

Third, intersectoral cooperation with other departments is negligible, while coordination among divisions within the same department is wanting. As discussed in the section above on Public Health, there are separate departments whose work influences health. A planning approach that is not sensitive to such intersectoral work falls short of accomplishing its objectives. For instance, the Department has not been involved in setting standards for drinking water. This has resulted in periodic outbreaks of water-borne or water-related diseases that could be prevented.

In fact the issue of intersectoral collaboration is only one among relationships the Department must forge to improve/assist it's functioning. There is the matter of Externally Aided Projects that are centrally funded and centrally implemented. Externally aided projects refer to the India Population Program, National TB Program, and the Karnataka Health Systems Development Project. The programs tend to have a level of professional expertise and funding that is absent in the Department. It is an interesting observation that during the maintenance phase, the superior management resources under these programs considerably taper down. An additional weakness is that the programs only address one aspect of health and fail to address the spectrum of health, for which the Department is responsible. There are no formal links among these programs and the Department. However, there are informal links that results in collaboration between practitioners of the two agencies. It is only collaboration at the practitioner level by which patients are treated holistically.

Human Resources Staff Development

Morale among department staff is quite low. And it is one among a host of human resources issues facing the Department. Another is a woeful need for technical and administrative training. Periodic in-service training, workshops, certification courses are ways by which competence of existing staff has not been improved or Public Health values disseminated. On that note, physicians are not provided opportunities to take advantage of Post Graduate courses, an expressed need. And training has not been used to improve Public Health knowledge among staff, and subject noted as critical to the Department.

Morale has been affected by the veiled manner in which administrative procedures are carried out. The process of physician selection for advanced training courses or for transfers is not transparent. When training courses are available, the selection process is not made transparent. Transfers, too, are used as a mechanism through which favors or punishment are doled out. In the most telling example of department culture, medical practitioners and senior officers have been vested with powers of autonomy that they are unwilling to exercise. A culture that values

central decision-making or fears consequences of decentralized decision making pervades Department staff, the Report finds. In other words, officers are willing to be more cautious and wait for direction from superiors in the Department for fear of reprisal.

There is a general apathy among workers in the healthcare system and it pervades all levels of employment. It is particularly evident among enthusiastic staff that joins the department only to be robbed of their idealism soon thereafter.

Data Collection, Analysis & Dissemination

Lack of available administrative data, at least one that is user friendly, hinders the efficient functioning of the Department. "There is unfortunately no complete information on the various institutions within the Department from the Subcenters, PHCs, CHC and upwards. There is no consistency in the figures reported on posts, vacancies, equipment available and condition of the equipment and the like." (p. 284 Report) Neither is there an assessment of how healthcare delivery is compromised due to inadequate staff, equipment and other resources.

The Health Management Information System (HMIS), a management information system, existed for a few years before being abandoned by staff. It collected the minimum records at Subcenter level and produced a report that contained data folded from the PHC level to the District level and then recapitulated at the State.

Even the manual data collection process in place today at the Subcenter level is difficult to access by planners. The Report identifies a muddled administrative structure, and a confined outlook as reasons. It is hobbled by data that is vertically integrated (program specific), lacks standardization, duplicates information collected, and analysis carried out at high levels in the Department that prevents immediate interventions at the Subcenter level.

Three different areas are currently responsible for collection and analysis of statistical data: The Bureau of Health Intelligence (BHI), The Demography and Evaluation Cell (DEC) and statistical units assigned to Divisions in the Department. Separately, the Director of the Bureau of Economic and Statistics is responsible for collection of birth and death registration records using revenue officials and notifiers at the field level. The BHI is administratively located in the Department's Health & Planning Division whereas the DEC is under the Division of Reproductive and Children's Health.

In terms of data collection, BHI is primarily responsible for production of the Annual Administration Report and Morbidity and Mortality reports. It is also responsible for generating information on bed strength of medical institutions, conditions for which patients are treated (snake bites, indoor deaths) and progress report on the rural health system, among others. The DEC, which is part of the State Family Welfare Bureau, is responsible mainly for evaluating Reproductive & Children's Health (RCH) program and data pertaining to the Family Welfare Bureau. To underscore the dispersed nature of data collection, the Report points to the presence of statistical units in various sections of the Department such as divisions of Health Education and Planning or Program Officers for specific programs, TB, leprosy, malaria and filaria. The administrative responsibility for statistical units lies with respective officers for the programs. To complicate the matter further, statistical units are actually on deputation from the Directorate of Economics and Statistics.

Healthcare Delivery Sites

As of 1998 data, the Department has 8143 subcenters, 1676 Primary Health Centers and 253 Community Health Centers. There is no standard for a Primary Health Center; they vary in the size of the population they serve and the services offered. Referral systems, those not addressed here, are more widely used for primary care. The Department does have a healthcare system that is geared towards treating progressively more serious conditions. Specialization of the healthcare system increases from the subcenter, to the CHC, to the Taluk hospital to the District hospital and finally teaching hospitals or specialty centers. Transport has been cited as one of the referral problems. When a patient reports to the PHC, patient is referred to the sub divisional level hospital, but is prevented from getting treatment because there is no transportation means for the person to go to the treatment site. Though access barriers is a separate subject of study, transportation as an access barrier has been recorded by the Report.

The healthcare delivery sites themselves (subcenters, primary health centers, Taluk & district hospitals) face persistent problems of inadequate staff and vacant posts. Some of these posts are rural. Others are deemed undesirable by upcoming professionals charting an ambitious career path. Physicians cite a lack of social and professional facilities in physically remote locations as reasons for their reluctance to accept posts.

Many of the vacancies for physician posts have been filled, temporarily or in some instances for much longer duration by contract workers. However, ancillary staff vacancies, such as for male health workers and lab technicians continue to present a problem. In instances when physicians have been hired on a contract basis to address shortages of physicians at PHC sites,

they have remained in this status for several years. In addition, there are shortages of resources, from phones to necessary prophylaxis at PHCs. Evidence suggests that even where equipment is available for laboratories, the laboratory sits idle because staff are not trained to use it. This is a gross mismanagement of resources.

Similarly, an issue facing secondary and tertiary care centers is the mismatch between needs and available services/resources. The Report points to a KHSDP study that showed a mismatch in the 252 hospitals that were upgraded as part of the KHSDP project. Mismatch here is between beds and the population size, equipment and the training required for staff to use it or available medical services and the services the populations needs. Emergency services at all levels are compromised due to lack of dedicated ambulances. The Report also expresses concern over Emergency Medicine becoming a specialization field. Physicians, particularly those working at the PHC level, will be required to detect and treat emergencies before transferring the case to a more specialized center.

Multifaceted Collaboration

The nature of the subject of health dictates that the Health Department's work requires collaboration. These include voluntary organizations, private healthcare providers (hospitals & doctors), indigenous healers, the community, locally elected representatives of the Panchayat Raj Institutions (PRIs), other Departments in government and the list goes on. Formal and informal relationships are an essential tool for the Department to discharge its duties. While there is communication between these agencies/individuals, the Department does not have direct and formal means of collaboration. The Department suffers non-cohesive planning and gaps in service.

"It would be relevant to note that certain statistical/reporting activities relating to RCH and PHCs are carried out by independent agencies with minimal coordination with the DHS." (p. 316 Report) For instance, in terms of drug procurement, a center called the Centre for Operations Research and Training (CORT) conducts analysis of drug & equipment availability at the PHC level. The information is shared by CORT with the Department but it's not clear whether the data is supplementary to data collected by the Department itself, whether it is new information and what is done with data when shared.

Health is addressed directly or indirectly by various non-government organizations (NGO), whether it is in the running of a hospital or dissemination of nutritional supplements or organizing rural women's empowerment. There are a number of NGOs registered with the

Department but under various programs and in different capacities. There are 1709 hospitals not operated by the Department. In fact Karnataka's private or voluntary sector boasts of operating more than 56% of the hospital beds. It is important to keep this in mind for planning and therefore elucidate further details such as the hospitals' geographic distribution, their areas of specialization and the socioeconomic status of the population they serve.

Despite the large number of NGO and other agencies providing healthcare services, and services that impact health objectives, the Department has not incorporated their functions and scope into Department planning. There is any number of missed opportunities for ongoing mutual collaboration. Information of this sort would contribute to comprehensive planning.

The Department has varying responsibilities for delivery of healthcare services depending on the kind of local government structure. In non-urban areas, the Department is responsible for all aspects of healthcare delivery. In urban areas, the city corporations, not the Department, have responsibility for local health. As a result, city corporations manage healthcare personnel without much collaboration or opportunity for monitoring by the Department.

The Report also records there are inadequate efforts by the Department to involve people. We presume failure to involve people includes PRIs as well. The Report does concede PRIs are not adequately prepared to participate. A resulting downside is that PRIs are not involved in decision-making at community level.

C. Medical Education

The third subject the Taskforce was asked to address is that of medical education. Here too, the Report observes shortfalls in the system that impact delivery of healthcare services to patients. The current education system is found to emphasize academic excellence to the extent of excluding humanistic aspects of the medical education system. These include, aptitude, moral and ethical conflict resolution, etc.. The emphasis of the Medical Education system is on clinical, secondary or tertiary care. Community Health Services training is not provided at all or if provided is clearly inadequate.

Recruitment of students to medical and other clinical colleges focuses on academic excellence. Placing a premium on academic excellence has resulted in compromises in student's aptitude for patient care and regard for social obligations to society as qualifications for selection. Similarly, it is thought that the teachers themselves lack an awareness of community perspective.

Teachers do not have provisions to engage in continuing education either to keep abreast of developments or as a springboard for professional advancement.

Consequently, the Medical education system does not place emphasis on serving the community, leaving graduates insensitive to the needs of medical practice in rural settings or urban settings in the government sector. Medical students also tend to be unaware of administration, particularly in rural areas where administration must accommodate various resource shortages.

There is a disconnect between teaching institutions in the State, qualified medical professionals necessary for services and the number of students in medical, dental and other colleges. The number of institutions offering courses has gone up as well. 23 of 172 medical schools and 38 of 123 dental schools in the country are located in Karnataka. At the same time, these institutions face teaching staff shortages in the order of 30%-40%. The Report does not speculate on the effect of staffing shortages but suggests quality of education suffers.

In terms of Department staff education or training, an ongoing, competent training program is lacking. Divisions within the Department conduct targeted trainings. However, opportunities for continuing staff education are not offered or available. There are no linkages between teaching/training institutes and the Department that the Department could exploit for mutual benefit.

III. Recommendation for action

With its mandates clearly spelled out at the outset, the Taskforce's responsibility after identifying deficiencies and gaps was to address them. In developing its recommendations or specifying a course of action, the Taskforce has attempted to do so with ideas of equality, integrity and quality in mind. And as the subtext for implementation, it includes administrative transparency, local involvement, and intersectoral participation. In other words, the taskforce proposes these ideas as an ingrained component of planning. Incidentally, it is also a mandate of the Taskforce that it be involved in implementation activities.

The Report, in fact, proposes a planning process to be initiated by the Department as a first step to implementation. A recent workshop organized by the Department on the Karnataka State Integrated Health Policy is an indication of the weight of the Taskforce's recommendations. In fact, many of the recommendations made by the Taskforce interim have been accepted and implemented.

A. Public Health

Public Health is an area underserved by the Department. From the lack of intersectoral coordination to the focus on curative care to the lack of Public Health officials in the Department, it is clear that Public Health is a neglected subject. To do the field justice, the matter has to be approached holistically.

Determinants

The Report makes specific recommendations to tackle the determinants of health such as introducing standards for drinking water and procedures to monitor the water. There are innumerable recommendations to tackle each communicable disease, handling of solid waste, pollution, non-communicable diseases and occupational health. Recommendations even include construction of toilets in schools to tackle sanitation lapses. Yet another recommendation suggests the Department take "steps to... publicize and bring in greater transparency in the functioning of the State Pollution Control Board including the punitive measures taken against the polluting industries." (p 61 Report)

The last example makes it clear that the larger issue of addressing public health is one of administration. The Department cannot administer its duties in a vacuum. And determinants of health are, as stated previously handled by different departments at the State. The Department of Health cannot simply dictate terms to the State Pollution Control Board. Health Department must actively collaborate with other Departments to address health issues in a comprehensive manner.

Report recommends formation of a Commission on Health and includes in its membership various Division chiefs from the Health Department, the Director of Medical Education and Director for ISM&H plus health care professionals from the community. More details regarding the Commission are provided in the subsequent section. It falls short of being inclusive in that it doesn't include departments of water, power, representatives, for instance from the Pollution Control Board or municipalities.

Primary Healthcare

Recognizing primary healthcare's importance in healthcare delivery, the Taskforce issued interim recommendation that included corrections for delivery of primary health. Staff vacancies were

to be filled immediately. Necessary equipment for laboratories and for primary health centers was purchased.

Changes in the administrative structure will be undertaken to weave delivery of primary healthcare into the larger context of keeping populations healthy. Programs such as RCH, TB and Blindness will be managed so that there is more coordination between these programs and the Department's efforts to deliver healthcare. Subject is discussed in the next section on Department Management.

Efforts will also be undertaken by the Department to involve non government practitioners, such as general practitioners, local healers and voluntary agencies in better coordinating delivery of primary healthcare. Department will also begin to work with the local community and PRIs to be involved in decision making. Alternative and possibly more powerful avenues for primary healthcare delivery will be considered. For instance, health education and promotion are powerful tools to increase utilization of preventive healthcare services or can even bring about changes in health behavior that ultimately result in improved health status. In that vein, schools will be used to disseminate health education information, where it would reach children at an early, impressionable age.

Disease Surveillance

Report recommends Department of Health to establish a separate unit for Disease Surveillance. Staff will be trained about maintaining a Disease Surveillance system and how to use it for rapid interventions. The weakness of dispersed data collection and analysis will be addressed by this unit. Recommendations also outline a system for collection of data, analysis and most importantly dissemination of data. Data will be used for conducting investigations, developing intervention responses and also for statistical purposes. Report even provides suggestions on the diseases to be included in surveillance. And last, it leaves with a proposition for the Department to expand Disease Surveillance into what it terms Public Health Surveillance.

Disease Surveillance will be implemented at the District level in each District. The District Health Officer (DHO) will be directly responsible for managing surveillance work, and timely data sharing. It will be DHO's responsibility to ensure that data collected is not restricted to government sites but that data is collected from all healthcare providers in the District. Healthcare institutions will be educated about the importance of sharing patient diagnosis information with the DHO within the same day for surveillance work. Staff reporting directly to the DHO will carry out analysis (with computer systems or without), record any disease

clustering and inform the DHO. DHO will coordinate outbreak investigation. And feedback will be provided to all reporting stations in the form of monthly newsletters.

A few diseases will require etiological confirmation before they can be statistically reported. However, if laboratory services cannot be used within a reasonable time, investigations and interventions should be carried out while pending etiological confirmation. The Report recommends establishing a microbiology laboratory in each District for this purpose along with serving its traditional clinical purpose. At the state level, it is recommended that a central Public Health laboratory serve as a reference lab and also undertake more complicated investigations. Building on the importance of public health, all District public health laboratories will report to State Public Health Institute.

B. Healthcare infrastructure

Given the central role the Department plays in the delivery of health and that the Taskforce is a body constituted by the Department, the recommendations necessarily focus on the Department. Based on the gaps identified in the findings, one of the major recommendations of the taskforce is a reorganization of the Department. The extent of reorganization reaches down to the primary health center and moves up to the Planning Division. In proposing reorganization, the Report cleverly attempts to address many of the shortcomings highlighted in the previous section.

Department Management

The two glaring administrative themes that emerged from the Taskforce's findings were a lack of sensitivity to public health issues and a centrally empowered Department structure, both of which were seen as impediments to achieving the department's objectives. The Taskforce concludes that an overhaul of the Department is essential to fulfill its objectives. It recommends the development of a strong department, with focused objectives and empowered staff. There is ample work to achieve what is proposed versus how the department currently functions.

Fig. 1. State Cadre divisions under the Department.

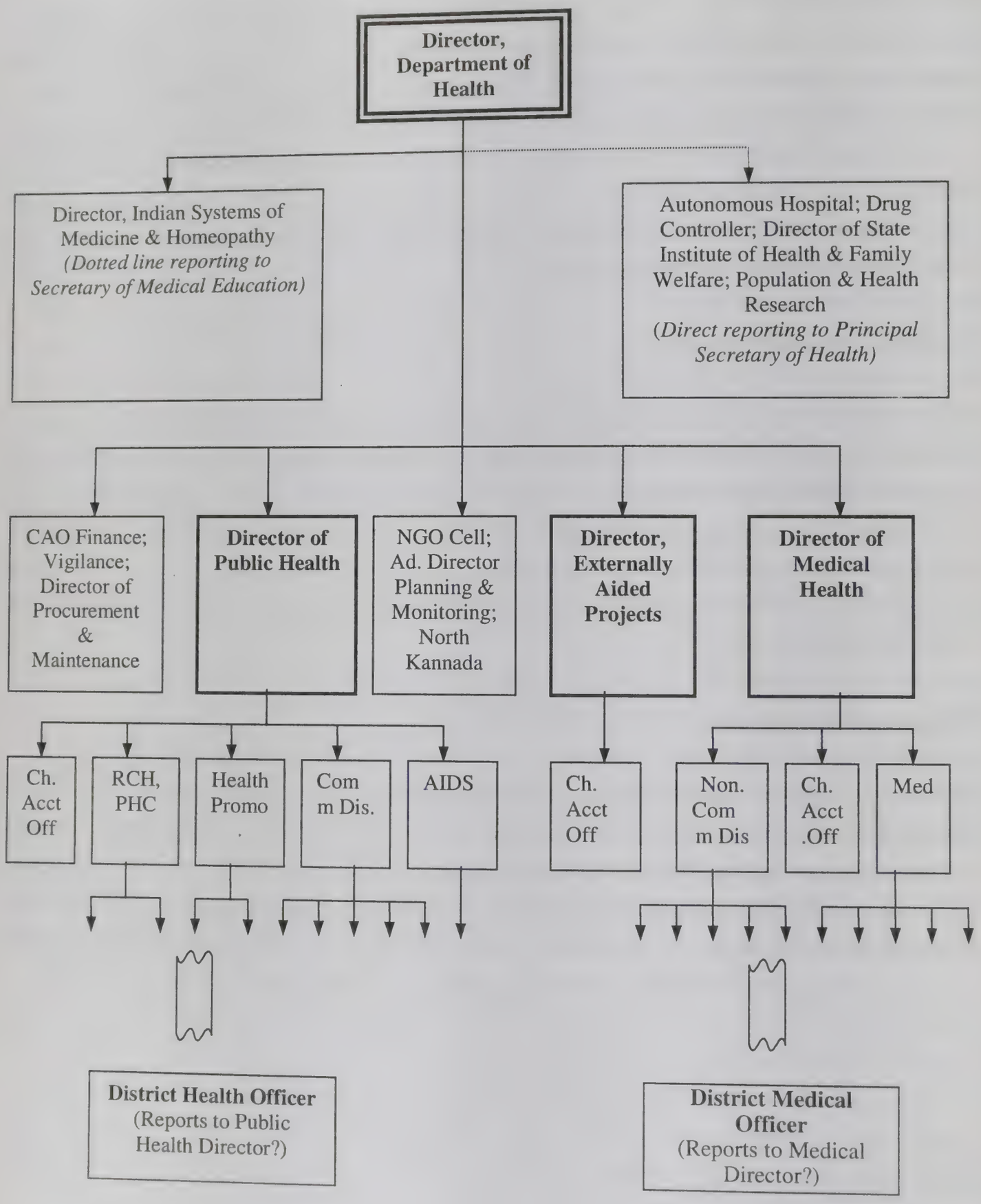


Fig. 2. District Cadre at the District Health Center or District Hospital. (Reporting to the Zilla Panchayat).

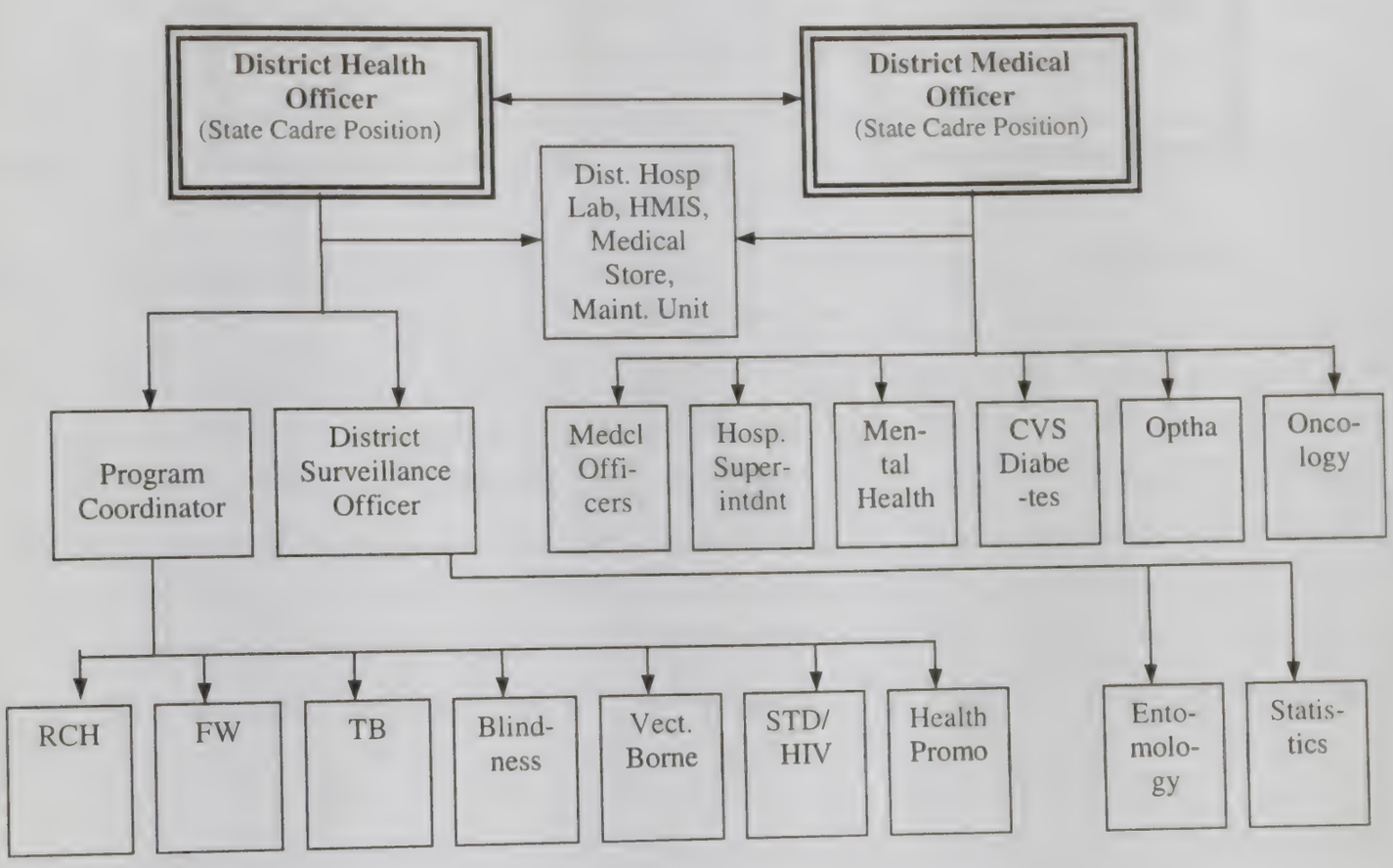


Fig. 3. District Cadre staff at Community Health Centers or Taluk Hospitals

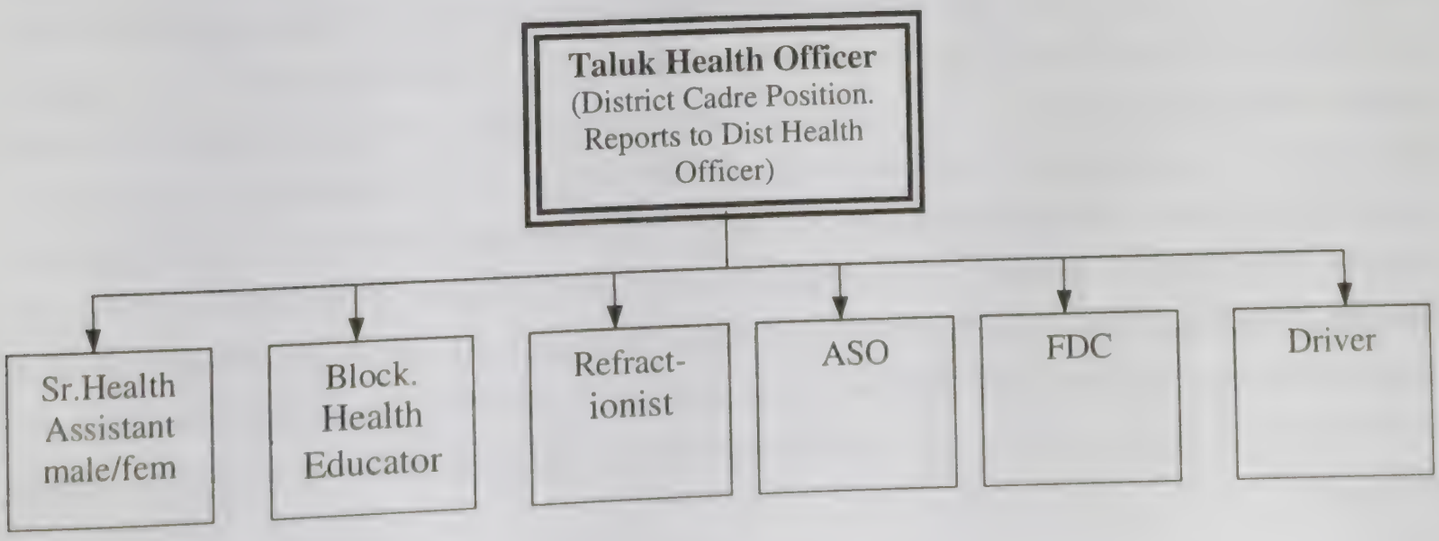
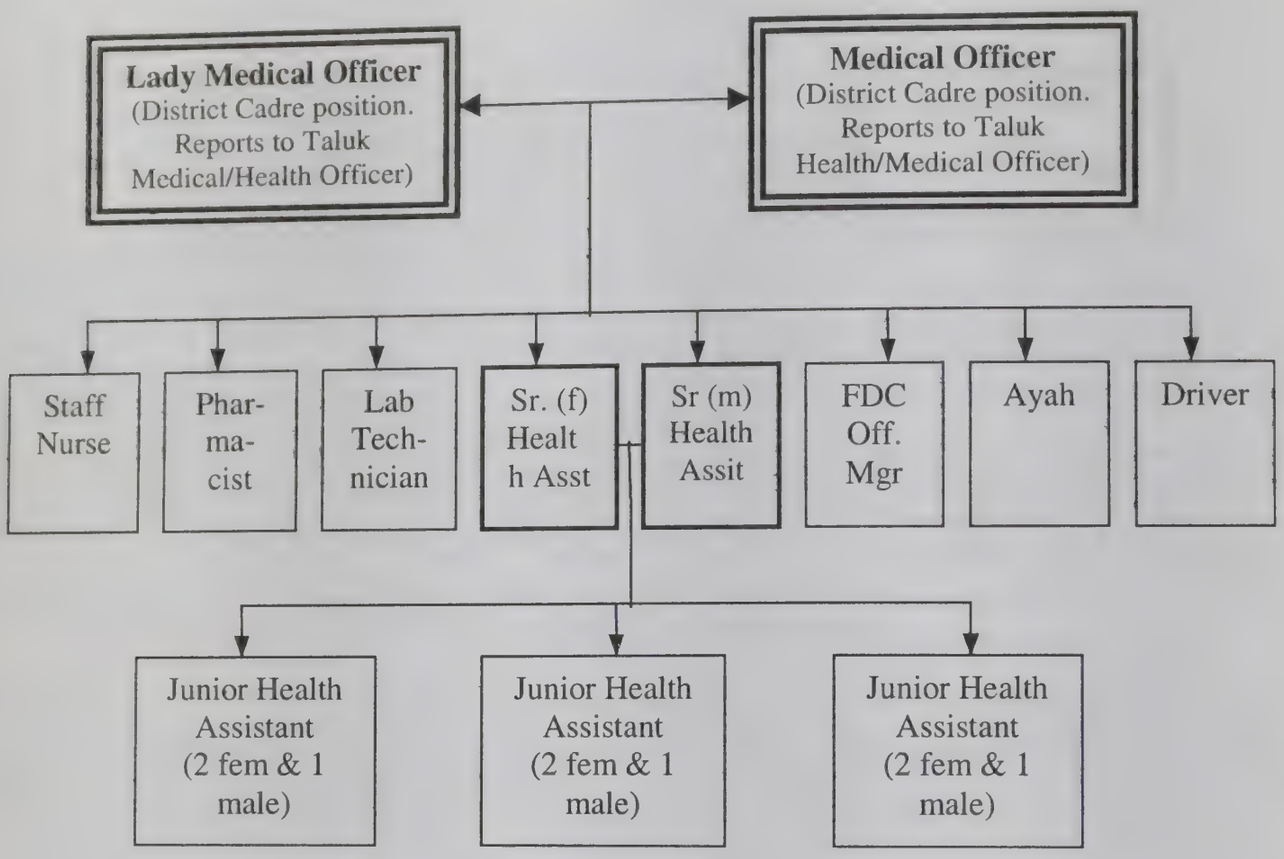


Fig. 4. District Cadre staff at PHC reporting to the Zilla Panchayat



State Cadre vs. District Cadre

In the proposed structure, the Department has been divided into District Cadre staff and State Level employees. Staff below the rank of District Health Officer (DHO) and District Medical Officer (DMO) will belong to the District Cadres. The DHO, DMO and all other senior staff belong to the State Cadre. DHO and DMO have been deemed officers of the ZP with administrative reporting responsibility to the Department. The ZP will become the nodal agency for all activities of the Department at the Taluk and Gram Panchayat levels. A partition of this sort has been suggested specifically to give the Zilla Panchayat (ZP) control of the Department at the District level and below. Activities of the ZP will include recruitment of staff, postings, transfer of personnel, disciplinary action and all related matters to the administration of healthcare delivery. The Chief Executive Officer (CEO) of the ZP is the person who has been assigned the role of Controlling Authority of Cadre staff. And the Department's role is seen as that of monitoring the activities of the ZP and setting standards for the efficient delivery of services.

However, it is the Department that will be responsible for determining staffing levels and norms for office hours at the Primary Health Center (PHC). The Report proposes procedures for candidate recruitment to the District Cadre. Suggestions include the formation of a District Recruitment Committee, which would consist of Department staff from Deputy Commissioner down to the DHO, or formation of a Local Services Recruitment Board. The Department would stipulate rules of recruitment, uniform pay scales and strongly favor recruitment from respective Districts. Movement from the District Cadre up to State Cadre will be based on a promotional basis.

Medical Care vs. Public Health

The Department has been divided into a Medical stream and a Public Health stream in the proposed structure to address neglect of Public Health. While the former will be responsible for acute clinical care at the individual level, the latter will be concerned with disease & disease patterns in the population as a whole and developing steps to address it. These two vertical streams will be present both within the District cadre as well as the State cadre. Both streams are accorded the same seniority within the department but the size of the Public Health stream is larger due to the nature of its work. The functions of the two separate streams, however, are distinctly different.

The responsibility of the Medical stream will include management of specific disease programs, treatment of diseases at the various health centers and primary responsibility for administration of the same health centers. Disease Surveillance, externally aided projects, health promotion and nutrition will come under the purview of the Public Health stream. At the District level, the DHO and the DMO will have responsibility to institute an efficient surveillance system in their area of responsibility. These two heads at the District level will have shared responsibility for procurement, laboratory services and an information/data cell.

Multifaceted Collaboration

To address the issues of vertically integrated programs, involvement of the non-governmental sector and to foster intersectoral collaboration, the Report has modified the infrastructure and proposed procedures to alleviate the current problem. It must be noted that as far as involvement of the PRIs are concerned, the Report has created a structure for ZP participation. However, Department staff at the State level will monitor its work.

To counter health programs focused only on one disease or one issue, the Report has reorganized the Department by establishing a Program Coordinator at the District level to promote coordination among the programs. It will be the Program Coordinator's responsibility to attempt seamless delivery of healthcare across programs.

Additionally, a Cell will be created directly under the Director of Health to serve as the single point of contact for all NGOs, and other organizations working in the field of healthcare. The Cell will have responsibility to keep track of all NGOs and work carried out by them. It will also been assigned the task of creating a streamlined procedure to keep NGOs abreast of Department developments and to involve these NGOs in healthcare deliberations and projects.

The Report has recommended the creation of a Commission on Health to address the issue of intersectoral collaboration. Membership is mostly health and health allied while interestingly not including PRI members. The Commission, that is to be chaired by the Director of the Department, includes representatives from medical education and ISM&H and has been assigned responsibility for development of Perspective Plan, ensuring public health's importance in health services and monitoring inter-sector issues. The mechanisms for interaction with other departments, such as water, education, are not delineated. The Report identifies an absence of registration and accreditation system for healthcare providers to keep the Department apprised of these groups and their activities. Requiring a registration system will, at least, keep the department apprised of these facilities. Moreover, the Department could exercise opportunities to monitor and audit these healthcare providers.

Healthcare Delivery Sites

PHCs, CHCs and hospitals face staff vacancies, primarily due to problems of placement in remote areas. The Report recommends incentives including honorariums as high as Rs. 5000 per month. Another consideration will be to hire alternative medical practitioners or paramedical professionals such as Licensed Medical Practitioners, nurse practitioners or physician assistants to fill gaps.

Report proposes that shortages of male health workers will be filled immediately given the nature of their work. It goes further to state that the technical control of the worker will be with the PHC physician but administrative control will reside with the Gram Panchayat. Similarly, there is no data to show that patients prefer female health workers or that utilization of health services by women is compromised in rural areas. Possibly as a preemptive measure, the Report does recommend the Department hire, train and post a lady medical officer at each primary health center.

With the health of the urban poor faring no better and sometimes worse than the rural health of the poor, the Report suggests imposing a standard of one urban Primary Health Center per 50,000 population. Also as an attempt to better serve the population, the Report suggests "existing resources such as health centers, urban family welfare centers and maternity homes be mapped and their services consolidated." (p 25, Report)

Data Collection, Analysis & Dissemination

A newly established Division of Planning & Monitoring is designated responsibility for collection of all budget data, strategic planning and, significantly, of being a repository for HMIS. It is proposed that a GIS be established in the same division under HMIS. Further it is proposed that strong statistical units will be established in the office of the DHO and DMO to analyze data and generate reports to implement interventions at the local level as well as to transmit it to Department headquarters.

"The HMIS should be an effective monitoring tool to assess the performance of the system and which provides for informed planning and decision" by the Department. (p 322, Report) HMIS will be expected to work in concert with the Department's Disease Surveillance System and Geographical Information System (GIS) for action and planning at the local level. HMIS in particular is expected to help the Planning and Monitoring Division to continually improve Department functioning.

The Report finds the Department has a committee to standardize various data elements collected by program officers, health workers at the subcenters in order to develop a comprehensive database from which any number of useful analyses can be carried out. The committee is also looking at the use of a computerized system in which to house the database so as to more robustly use the data available. In fact the State has gone so far as to sign an MOU with a software company to develop software that can synthesize disease surveillance data, administrative data and geographically relevant data to provide decision makers a more integrated picture. The intent is for decision makers, whether at the District level or at the State level, to have a complete picture of the three interrelated elements before implementing interventions.

C. Medical Education

Society benefits by cultivating the caliber of graduates emerging from medical institutions. Careful consideration during student/faculty recruiting and training is one strategy. The Report suggests focusing on extra-academic traits such as a student's aptitude for social commitment

during recruitment, expanding curricula to teach morals and ethical dilemma, using humanitarian approaches to health as opposed to disease oriented approaches and inculcating a sense of accountability to societal health. Further, it feels students must be oriented to other systems of medicine and understand importance of allied health services such as nursing. "Programmes should provide opportunity for the students to understand social structure, its functions, norms and values and social factors which precipitate disease condition in the community." (p 249, Report)

Department will require each Medical Institution to adopt three PHCs along with all of their affiliated sub centers. The recommendations go further to say that medical institutions will be given full administrative and technical control of running these PHCs. The Government will be required to provide funds in the form of grants-in-aid. Grants will provide medical students the ability to implement primary health concepts and also to learn about management of the centers.

Department will be required to discontinue issuing essentiality certificates for the establishment of new clinical schools for a period of two years. Essentiality certificates are necessary for new schools of medicine, nursing, dentistry, pharmacy, etc.. The rationale is that staff shortages at existing campuses are yet to be addressed; it does not make sense to discuss addition of new universities when existing ones are failing.

The State Institute of Health and Family Welfare (SIHFW) will be upgraded as the nodal center for staff education and training. It will be responsible for addressing deficiencies in Public Health awareness and for developing a course in Public Health. Courses will be of the caliber leading to certificates, diplomas or post-graduate degree in Public Health. It will also be responsible for providing ongoing training for Department staff in several subjects. The importance of SIHFW's change in role is illustrated by its proposed reporting relationship to the Principal Secretary of Health.

IV. Our Suggestions for Implementation

The healthcare recommendations of the Taskforce, as stated numerous times in this document, are thorough and extensive. Major findings and recommendations have been discussed in sections II & III of this document. Each of the recommendations is of merit and worthy of adoption. But under the constraints of political, budgetary, administrative and personnel resources, implementing each and every recommendation is unfeasible. It is important to prioritize and choose, but then, who prioritizes? Who chooses? In section IV, we suggest three themes around which the department might benefit from making investments now, investments that might reap long term and sustained benefits.

First, we consider the legitimate role of the Panchayat Raj Institutions as elected government bodies to which the Department is accountable. This role implies a fundamental difference in the existing relationship between PRIs and the Department. Second, we suggest investing in a system to encourage evidence based planning. Such a system would require investments to develop robust data collection, analysis and dissemination procedures. Third, we encourage the Department to approach healthcare in an administratively holistic manner. By this we mean the Department would cultivate intersectoral relationships, official or otherwise, and use the intersectoral approach to address issues of healthcare.

ARE THERE EXAMPLES FROM WHICH WE CAN LEARN?

We can draw lessons from successful examples of policy implementation both within the State and from other states in the Union. Karnataka itself had a Panchayat system of governance in the 1980s, provisions of which were limited when drafting the Panchayat Raj Act of 1993. In the previous system, Karnataka and the government bureaucracies deferred to the local electorate on issues that impacted the local population at the local level. The State of Madhya Pradesh, too, has seized the opportunity to expound the ideology of participative governance in all sectors, education, water and healthcare schemes. In each of these instances, the decision makers were also the ones affected by the decisions and moreover, were responsible for its implementation in a hands on manner.

Karnataka's Decentralization, 1980s

In Karnataka, the constitutional amendments led to the passing of the Panchayat Raj Act, formalizing the establishment of local bodies and a process for local elections. (Karnataka Panchayat Raj Act) The Act divests powers to the Panchayat bodies but only generally describes the role of the Panchayat itself. In lieu of clearly defined statutory requirements, this paper makes a case for using local bodies to develop and implement policies as more effective means to ensure successful implementation.

With progressive legislation in place in Karnataka in the 1980s, all line Departments reported to the ZP at the District level. ZP Presidents were equivalent to ministers of the State and in fact wrote the District Chief Secretary's confidential performance evaluation reports. Empowered ZPs wrested control of programs in health and education towards local control and implemented innovative schemes. These institutions decided to hire teachers and local health practitioners. A couple of remarkable things started to happen as documented by the Krishnaswamy Committee report. (Krishnaswamy Committee Report) There was a significant improvement of enrollment rates in schools, a marked drop in absenteeism and even a noticeable

decline in dropout rates. Unfortunately, the sustainability of the program could not be studied because the system of governance did not last.

The Report found having ZPs and gram Panchayats manage civic services was very effective. ZPs successfully exercised governance and were rewarded with expected performance levels by government bureaucrats.

Madhya Pradesh Education Guarantee Scheme

Yet another example of a successful social program also has its basis in a locally defined, locally driven model. Experience from Madhya Pradesh suggests that using local governments and local communities can lead to successful adoption of State aided projects. More recent experience has shown that such an approach also leads to the success of the program itself. (Rajiv Gandhi Mission project on Education)

The State of Madhya Pradesh undertook an education guarantee scheme in 1996. The state proposed that groups of 25 students (less for SC/ST) that did not have a school within one kilometer could start a school, supported by the State government. The group would be responsible for finding a location for the school and to hire teachers. In other words, the State would not centrally control hiring of teachers. Instead, the State would agree to the following responsibility. It would propose minimum necessary qualifications for teachers, compensate teachers (hired by the groups), by paying a modest honorarium, provide school books and in general provide support to the running of the school within ninety days.

By leaving it open to the general public to organize themselves and identify a need for services, the Madhya Pradesh government embarked on a committed path to placing decision-making power in the hands of the local people. 26,000 primary schools have been launched. Teacher absenteeism dropped considerably as the people responsible for hiring teachers now had the means to monitor performance on a daily basis. Previously, teachers were state employees with reporting responsibility to superiors at the state. The system did not foster an atmosphere of active personnel management. Innovation abounded when it came to the matter of finding solutions for schools. Teachers were found teaching under trees, at local parks, and in buildings (abandoned or otherwise) or land donated by local people. Literacy rates improved dramatically, as the most recent census attests. Rates improved by over 20%.

Madhya Pradesh Health Scheme

The third example is more recent and is only now being implemented in the State of Madhya Pradesh. The program is a recognition of the importance of health and health determinants. Swasth Jeevan Seva Guarantee Scheme has been modeled under a rights based framework. It places the onus of funding of the program on the State government but at the same time creates imperatives for local governments to fulfill obligations. At the outset, the State endeavored to build a Village Health Register. It began with a People's Health Survey to map the current status of health provision, providers, burden of disease, and the status of key determinants of health. The survey was conducted by residents of the village in concert with the Village Health Committee, constituted by the Gram Sabha. Survey data was used to build a grassroots level alliance among the villagers for health action. Data also formed the basis for the Village Health Register. Because local bodies at the District level were charged with developing District Health Action Plans, awareness was built at village level to use Survey data as basis from which Village Health Plans could be built. Village Health Plans would be rolled up into District Health Plans for incorporation finally at the State level. The program is off to a good start with establishment of the Village Health Register. Its effects on improving aspects of village health are yet to be seen.

Implementation of the program capitalizes on locally accountable, elected body representatives with a mandate for intersectoral coordination. Using local government structures, i.e. Panchayats, moves away from the problem of programs being implemented in a vertically integrated manner. The same Gram Panchayat representatives who are responsible for implementing health are also responsible for implementing other Department programs, i.e. water, sanitation or education. The Gram Panchayat is well qualified to identify duplication of resources as it is the junction where, euphemistically, the rubber meets the road, i.e. where policy and program meet. And when given flexibility to exercise power, it can leverage its intimate knowledge of needs, available funds, various intersectoral programs and benefit from the fusion of funds and energies.

A. Role of Panchayat Raj Institutions

In general, the Report underscores the importance of improving transparency, intersectoral participation and local involvement as key to effective implementation. While the Taskforce's report emphasizes mechanisms to improve transparency and a department commitment to local issues, it does not make a clear distinction between elected members (Zilla Panchayat) and Department staff (CEO, ZP). The distinction is critical in light of Constitutional Amendments establishing Panchayat governments. As a component of the 1993 73rd and 74th Constitutional

Amendments, policy development and program implementation must use the local *elected* government, i.e. (District, Taluk & Gram) Panchayats, as an instrumental arm of governance. The government has created a legal imperative by which locally elected leaders meet, discuss local issues and participate in a planning process that impacts the local area. Given that programs are State administered, the planning process involves working with the various departments at the State and submitting their plans to the respective State Departments. (GoI Report on Devolution of Powers)

Looking at the process from the other side however, one sees a distinct chasm between planning at the State level and its implementation at the gram level. Local priorities and limitations are overlooked in the State's bird's eye implementation of statewide programs. The Department of Health could well benefit in affecting health status by making involvement of PRIs a part of Department ethos. And there is some evidence to support the idea from examples described above.

Department reorganization proposed by the Report emphasizes public health, delegates more control to staff at the district level and addresses issues of human resources development. However, there is no formal association with PRIs. Given the success of programs described above, the Department could begin by recognizing the legitimate role of PRIs. After all, PRIs are duly elected representatives and equivalent to MLAs at the District level in that they enjoy constitutional office. Variations abound between Districts in terms of geography, priorities, funding, indigenously available resources and political sophistication. Would it not be this group of elected individuals, residents of the community, to identify needs of the community? Furthermore, the Panchayat Raj Act of Karnataka stipulates the requirement for a village health (and education) committee as a subcommittee of the ZP. Should the Department not avail of this group's local expertise?

Karnataka, as most other states, has failed to endow its PRIs with adequate authority and resource base to function as effective local governments. What is required is real devolution of governance to PRIs rather than mere decentralization of implementation of programs planned and decided upon elsewhere. However once the PRIs become functionally responsible for primary healthcare as well as public health facilities like drinking water supply and sanitation, the nature and functions of the Medical and Public health department at the state level will change radically.

We propose modifying the District Cadre's reporting structure to involve PRIs. DHO/DMO and all staff below in the District Cadre could report directly to the elected representatives of the ZP or its health subcommittee (Fig. 5). Likewise, at the PHC level, the Medical Officer could report to the village health committee of the Gram Panchayat or directly to the Gram

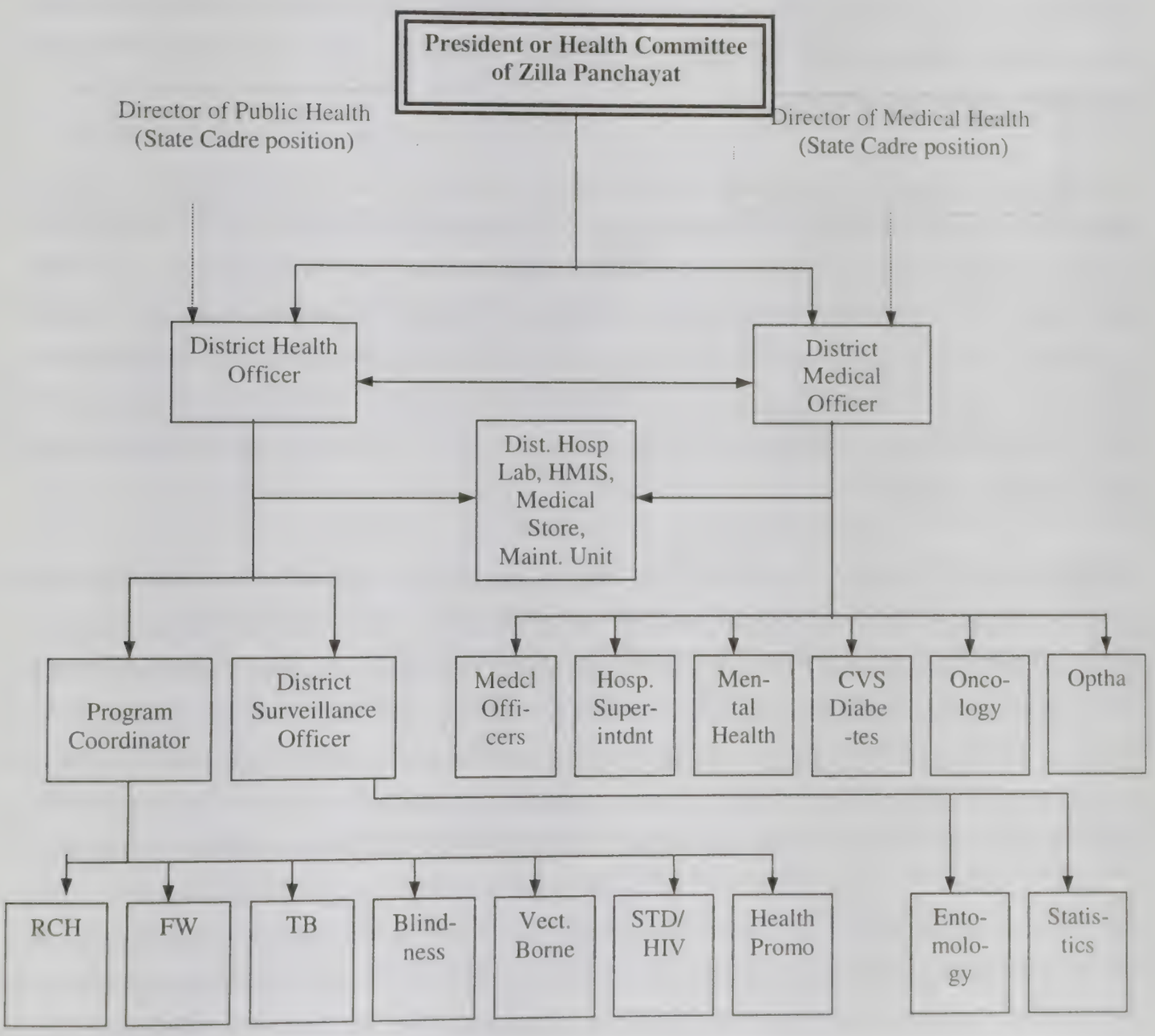
Panchayat. The Medical Officer could be required to work with the Gram Panchayat for staff recruitment, improvements to the PHC such as purchasing bicycles, coordinating with Community Health Center etc. but would retain responsibility for managing the PHC on a day to day basis. The Gram Panchayat, along with the Medical Officer could also be responsible for developing a Village Health Plan and ensuring its inclusion in the District Health Plan. The same working/reporting relationship could be evolved for CHCs, Taluk and District hospitals.

The idea of PRIs recruiting healthcare staff is an example of devolving governance to PRIs. The concept has experienced success with teacher recruitment and retention efforts in Madhya Pradesh. The ZP Health Committee could have responsibility for monitoring staff shortages and mobilize efforts to recruit local clinical workers or lab technicians. Alternatively, the committee may feel that it could benefit in staff retention by training local residents to meet essential qualifications. Many voluntary hospitals serving tribal groups are doing just this, training tribal women in nursing or other allied health fields to meet local needs. Providers hired from the local community can be policed for performance through formal and informal means. The ZP health committee, the very people utilizing services of the clinic, could immediately address staff ineptitude, sloppiness or apathy. Taking it one step further, Gram Panchayats and Zilla Panchayat health committees could be required to write performance evaluations of staff. Evaluations could then be used as the basis on which staff is rewarded.

Dissemination of healthcare funds could be shifted to the ZP as well, with input on the dissemination of funds to be provided by the ZP health committee. To consider, the health committee already deliberates on health and healthcare, as per its mandate. It develops a health agenda that is incorporated into the District Plan. And where consequent administration of the District health agenda is concerned, it could be discharged responsibility to manage funds tied to health and healthcare. For example, suppose a ZP health committee decides to tackle diarrhea within its District. It could be given the prerogative to decide how the funds are best used within that District - by spending on improving water supply, by providing medication, by addressing food preparation issues, by health education or a combination of the four. Of course, the health committee is not expected to do this in isolation of the Department (be it of health, water or other), but necessarily in concert with the Departments concerned. The power of coordination could be left to the committee as it is in a position to not address the issue in a vertically integrated manner. It must be emphasized that PHCs and subcenters ought to be given flexibility to use the budget for locally identified needs.

A change in working relationship of this order might necessitate building support systems to make the transition smooth. Training programs - for both Department staff as well as PRIs on their roles and responsibilities - might be one option, political will -an order issued by the State government to Departments - might be another, generating a people's mandate - identifying the needs of the villages and Districts - might be a third, or of course a combination might be attempted.

Fig. 5. District Cadre staff at the District Health Center or District Hospital reporting to elected Zilla Panchayat.



B. System of Data Collection, Analysis and Dissemination

In a recent article about the work of the National Statistical Commission, Dr. C. Rangarajan underscores the importance of a HMIS and routine data collection system for the administration of Health & Family Welfare. In fact, he states it "is a prerequisite for studying the problems of health and diseases, effective administration of health services and evaluation of effectiveness....." (Rangarajan) It is abundantly clear throughout the document that a lack of data limits the ability of the system to function - by preventing evidence based strategic planning, by preventing administrators to respond to disease outbreaks efficiently, by preventing the department to staff adequately.

Disease Surveillance, for example occurs but not in a systematic fashion or an end-user friendly fashion. The scope of Disease Surveillance is covered thoroughly in the Report. We don't wish to add to it but do caution the Department to consider recommendations only as a guideline. The content of the Department's Disease Surveillance should be an outcome of the results of discussion with Panchayat health committees, other State Departments (such as Agriculture, Women & Children's Health) and researchers. Disease Surveillance should be more robust for more prevalent diseases, with provisions for investigation, dissemination and intervention built into the design early on.

Administratively, we suggest involving the PRIs (Health Committees or volunteers from the District) in designing surveys and actual data collection efforts. Methodological details could be developed with sensitivity to the local environment. Volunteers could be trained in scientific research methods, immediate analysis techniques and understand the basis for creating a database. Training could cover innovative techniques to elicit information from non-government healthcare providers or other Departments to investigate potential disease outbreaks. Students could be asked to conduct a mock surveillance as part of curriculum to establish competence.

The maiden concerted data collection effort could form baseline data for each District, possibly giving ZPs evidence of critical health issues facing their District. The data itself could also be used by Health and other Departments as also by researchers to more closely study a particular issue. Overall design of the Surveillance System and planning would be conducted at the State level by Department staff. It would be important for the Surveillance System to make accommodations for data to be compared across Districts even when data is collected in various ways.

Administrative data could be handled by the State's HMIS. It would go a long way towards more efficient Department management. Armed with data, the nature of management moves from blind decision making to a debate on how best to manage with limited resources. Therefore, nature of questions moves from "In what area are there staff shortages?" to "there are staff shortages for a male health worker in a PHC in one District, but the people report they do not need any more clinicians." Department can choose not to hire a male health worker. It could be something even simpler. HMIS might show that a PHC does not have stock of drug A. At the same time, Disease Surveillance data shows that the disease for which drug A is the prophylaxis, is not endemic to that region. So necessity for drug is not immediate.

C. Intersectoral Collaboration

It would be of use for the Department to develop very specific linkages and a politically savvy strategy to impact determinants of health by working with other State Departments, pertinent organizations. Department leaders could establish working committees with other Departments whose purview impacts health. It would be obvious to state that the air we breathe impacts our health. But the Health Department cannot assume complete responsibility for air quality. The success of a holistic and public health oriented Department agenda impinges on establishing formal communication means with other Departments to address health issues. This ensures that sanitation is not discussed in isolation by engineers, water experts and elected representatives, but that such a dialogue includes Health Department staff, Departments of Primary & Secondary Education, Urban Planning, and scientists such as sociologists and psychologists in addition to other technical experts. Committees or avenues set up for communication with other Departments could include PRI representatives, i.e. ZP Presidents, in the information loop.

Establishing working committees alone is not enough. Most government departments including those dealing with medical care and public health have become administration oriented rather than function oriented. Even when budgetary allocations are in terms of specific activities, more attention is paid to staffing and financial audit procedures than to getting the job done quickly and efficiently.

For instance, in terms of data collection strategies for Disease Surveillance, we propose the establishment of a committee. The emphasis here is not on the establishment of the committee itself but in the objective it is expected to fulfil. The committee would a) identify areas of study, b)obtain consensus on process for data collection and c) develop strategy for dissemination of data to stakeholders including the Commission on Health. As a preliminary exercise, the

committee will identify a set of end users and potential uses for such data. Additionally, end users will be informed of the content and frequency of the Disease Surveillance information they are to receive. An example is the Department of Water's interest in outbreak of water-borne diseases or specific mineral deficiencies that may be indicative of problems with the water supply. Having completed this exercise in designing a Disease Surveillance system, the committee would be disbanded. The end users would continue to create demand and the Disease Surveillance Officer would be responsible for managing the Disease Surveillance system. Responsibility entails ensuring making adjustments in the system in order meet end users requirements as well. Disease Surveillance Officer who in turn would be accountable to the Director of Health would head the Committee. Composition of the Committee would include an epidemiologist, a statistician, an anthropologist, a sociologist, 3-4 chairs of Panchayat Health Committees, ZP Presidents, a healthcare researcher, and one member representative from departments of Primary & Secondary Education, Agriculture, Water Supply and Women and Child Welfare.

V. Conclusion

The Taskforce concedes that its weakest point is an absence of prioritization that would aid managers implement their charge. It maintains that its role was to present its collective wisdom and the Department's to determine priorities. We believe that the Taskforce's expertise is necessary in assisting the Department define goals and set priorities. Without the Taskforce's guidance in defining priorities, the Department's efforts are susceptible to compromises based on political or resource constraints. To prevent such compromises, the Taskforce would assist the Department prioritize and then, if it so chooses serve in a consultative capacity.

The suggestions in Section IV do not directly impact health but create an environment in which healthcare programs have a better chance of successful outcomes. Put differently, healthcare issues have not been prioritized - whether resources should be directed towards antenatal care OR cancer OR water supply and sanitation. We propose that developing priorities for healthcare issues should be a parallel exercise to the one addressed in Section IV. Our only comment is that these priorities should have clearly identified targets and specified timeframes for achievement, with accountability clearly assigned to an individual or department.

An example of how a healthcare priority could be implemented is described. Suppose a District sets diarrhea as its priority. The priority could be a result of a preliminary data collection exercise or it could be a recommendation of the ZP health committee. The objective could be

to reduce cases of diarrhea by 50% within one year in the District; the catch being that all stakeholders also agree to the objective. Stakeholders could include the Department of Water, Department of Agriculture, Board of Sanitation, Department of Nutrition, Department of Women's and Children's Health, Department of Animal Husbandry, NGOs. Each stakeholder could then be asked to adopt initiatives to address the objective in concert with other stakeholders. Initiatives could be periodic testing of water, decontamination of produce, improved methods to handle livestock, education program on hygiene to children etc., all in an effort to reduce diarrhea in a given District.

Initially, it may be that the Department of Health leads the initiative but the Department can evolve out of that role over time. Here, we use the example of administration of non-government healthcare clinics/hospitals. There are no qualitative standards that govern these hospitals. As more and more care is being provided in the private sector, issue of monitoring quality in the private sector becomes more and more important. Even if the State were to enact legislation, the resources required for enforcement will not be adequate. In the beginning, the Department of Health could lead the charge for oversight by identifying acceptable standards and then doing routine monitoring. Over time, NGOs would have to be brought into the monitoring fray if Department resources are to be used effectively. NGOs could be responsible for doing evaluations or could involve health committees (or volunteers) in the effort. NGOs could offer assistance (in the form of monetary, time, oversight, technical assistance).

As the Taskforce was constituted under the aegis of the Department, it is only natural that the emphasis of the Report is in modifying the Department infrastructure to impact health. The proposed reorganization of the Department addresses issues of local participation, data collection and intersectoral participation. But inconsistencies in the recommendations should be considered thoughtfully and not adopted blindly. For example, the notion of District Cadre promotions, which involve staff being moved out of the community to the State Cadre, is counter productive to the objective of building local commitment.

It must be noted that reorganization of the Department is being proposed without consideration for the recommendations made by the Administrative Reforms Committee. Reconciling differences will be a massive task. The duplicity of effort expended should be something addressed at high levels of government. For instance, has there been a dialogue between the Administrative Reforms Committee and the Taskforce on Health & Family Welfare? If not, do one set of recommendations supercede the other? What is the rationale for change?

What about the legitimate role of PRIs in the revised Department structure and in administering Department programs? A salient limitation of the Taskforce's Report is its failure to recognize the legal power of Panchayats as an arm of government to be served by the Department in carrying out its functions. There are several references to PRIs made in the context of oversight or as bodies to be manipulated by the Department to achieve Department goals. "The Panchayat institutions operate under the authority delegated to them under the Act and perform their functions under the supervision and guidance of Government." (p. 388, Report) To reiterate what was discussed in Section IV, PRIs are constituted of elected representatives whose right it is to self govern. In carrying out their responsibilities for health, education and sanitation, PRIs are constitutionally empowered to use State means to fulfill their responsibilities. The Department is an arm of governance and subservient to elected government. At the State level, the Department is accountable to the Ministry of Health, which in turn is accountable to the Assembly. Similarly, Department staff is (ought to be if not so) responsible to the ZP Health Committee, which in turn is responsible to the ZP at the District levels.

It is interesting to note that many of the interim recommendations made by the Taskforce have been adopted with zeal and implemented. Most if not all are related to Department administration. These include hiring and training of personnel, provision of additional funding for PHCs to purchase drugs and so on. The Department could exercise caution in adopting recommendations in a piece meal fashion. The strategy for planning and implementing changes must be a deliberate, methodical one. Its aim should be to bring about long term, lasting changes and work towards bringing about changes in the administration of healthcare that ultimately result in measurable improvements in health.

However, since healthcare priorities have not been delineated, it is unclear how healthcare programs will be implemented in the revised Department structure. How involved will PRIs be? Can the Department lead the way for other departments in how it plans and implements healthcare programs? Can it restructure itself to be a more agile Department, able to respond rapidly to health issues?

This document concludes with the thought that more debate is necessary before implementation gets underway full swing. A workshop organized by the Department, in conjunction with the Taskforce and for healthcare professionals, to generate dialogue on the Karnataka State Integrated Health Policy is a good start. But perhaps more rigorous discussion is necessary. After all the charge of the Department is a serious one - it has the onus of providing healthcare for the population. Time imperatives that are accelerating implementation should be set aside for a reasonable period to ensure that the planning process is thorough and thought through.

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M. A. Deepa is delighted to have recently joined the Center for Budget and Policy Studies in Bangalore as a healthcare consultant. This is her first foray into the Indian policy debate. Her interest in working on healthcare issues in India goes back many years. She was involved in project work in the early 1990s related to the development of a training program for the diagnosis and treatment of AIDS for medical students in Chennai. Previously, she has worked in the for profit health insurance industry as well as in government sponsored managed healthcare programs in Los Angeles. This has given her an interest comparing the way local governments work in the health field in the United States and in India where after the 74th Amendment local governments have become a reality. Deepa has a Masters degree in Public Health from the University of California, Los Angeles, with an emphasis in healthcare policy and planning.

C B P S

The Centre for Budget and Policy Studies (hereinafter referred as Society or Centre) is a non-partisan, non-profit, independent society established by a group of professionals based in Bangalore and registered under the Karnataka Registration of Societies Act in February 1998 (no 777 of 199701998). The President is Dr. D. K. Subramanian and the Secretary and Director is Dr. Vinod Vyasulu.

The objective of the Society is to contribute through research to understanding and implementing a process of long run, sustainable, equitable development in countries like India. Equity, as we understand it, extends across time - future generations must not be deprived of resources because of irresponsible use - and class and gender - all human beings have inalienable rights that society must ensure.

An area in which the CBPS has made a contribution is in the context of the ongoing process of democratisation and decentralisation following upon the 73rd and 74th amendments to the Indian Constitution. In this context, budgets of different governmental bodies are important statements of policy priority. Budget analysis at local levels is an area where much needs to be done. An example is the work of the Centre in studying the budgets of two zilla panchayats [Dharwad and Bangalore (Rural)] in Karnataka. This report, formally released by the Governor of Karnataka, Her Excellency Smt. Rama Devi on July 4, 2000, is being used in programmes to orient those who have newly been elected to local government bodies.

One way of meeting our objective is by providing inputs into ongoing debates in society on matters of policy priority by collecting and analyzing information and presenting scenarios on different options that face the public. Industry is one such area. The functioning of different sectors of industry, its impact on employment, livelihoods, productivity and the like, and the different options open to this country, in the midst of major global changes like the advent of the WTO, need careful study and debate. This monograph is a small step in this direction.

Another area of importance is ecological and environmental sustainability. The interface between local bodies and environmental programmes is another area of focus. CBPS will study the working of programmes like drinking water, watershed development, joint forest management to see how local bodies can contribute to the meeting of national objectives. Currently, the Centre is involved in projects in these areas in selected districts of Karnataka.

CBPS will remain a small body of professionals who will work by interacting and networking with others who share such interests. Working groups for different studies with professional membership will be set up, and will work with minimal infrastructure. Full use will be made of modern technology in this process. The results of such work will be used in training, in dissemination of results and in follow up programmes.